BACKGROUND PAPER FOR HEARING

BOARD OF PODIATRIC MEDICINE

IDENTIFIED ISSUES, QUESTIONS FOR THE BOARD, AND BACKGROUND CONCERNING ISSUES

PRIOR SUNSET REVIEW: The Board of Podiatric Medicine (BPM or Board) was last reviewed by the Joint Legislative Sunset Review Committee (JLSRC) four years ago (1996-97). The JLSRC and the Department of Consumer Affairs (DCA) identified a number of issues concerning this Board. For example, the JLSRC found that: 1) the number of public members in the composition of the Board was not sufficient; 2) specialty licensure for purposes of performing ankle surgery was not necessary; 3) the Board should obtain additional input and justification before prohibiting the advertising of "free foot exams" by podiatrists; 4) information concerning licensed podiatrists should be included on the Medical Board's internet verification system; 5) residency programs should be required to have at least a fifty percent pass rate for residents taking the Board's oral clinical examination; and 6) an external audit from the University of California system should be provided to the Legislature to determine if it is providing appropriate funds for podiatric medical training.

The JLSRC recommended continuing the Board of Podiatric Medicine and directed the Board to implement a number of recommendations and changes. Many of these recommendations and issues were addressed by legislation. With the BPM's support, SB 1981 (Greene), Chapter 736, Statutes of 1998: 1) enacted the nation's first continuing competence program for any doctor licensing board; 2) eliminated a special ankle surgery certification and examination; 3) changed the board composition by adding an additional public member; 4) sunset BPM's diversion program; and 5) required an audit from the University of California system to determine if appropriate funds were being provided for podiatric medical training.

In September 2001, the Board of Podiatric Medicine submitted its required sunset report to the JLSRC. In this report, information of which is provided in Members' binders, the Board described actions it has taken since the Board's prior review. Issues that the Board addressed as a result of the JLSRC's recommendations and other changes made include the following: 1) information concerning licensed podiatrists is now included on the Medical Board's internet verification system; 2) a public hearing was held by the Board to discuss the advertising for "free foot exams" and justification for prohibiting such advertising was provided; 3) the need for the limited license required to participate in a postgraduate podiatric residency program was justified; and 4) BPM's regulations were amended to require residency programs to have at least a fifty percent pass rate for residents taking the Board's oral clinical examination. The board also amended its strategic plan to address, among other things, the financial challenges brought by the declining number of licensees associated with managed care.

The following are unresolved issues pertaining to this Board, or areas of concern for the JLSRC, along with background information concerning the particular issue. There are questions that staff has asked concerning the particular issue. The Board was provided with these issues and questions and is prepared to address each one if necessary.

It must be noted that the BPM has endorsed the Federation of Podiatric Medical Boards' Model Law (Model Law) and has proposed that several provisions of the Model Law be incorporated into California state law. A number of statutory modifications would be necessary to implement the national Model Law. Some of the issues that follow stem from these proposed changes that would have to be amended into Article 22 of the Medical Practices Act.

CURRENT SUNSET REVIEW ISSUES

LICENSURE ISSUES

ISSUE #1: The Board is proposing a two-year requirement for post-graduate medical training, an expansion of the current requirement of completion of one-year of residency training.

Question #1 for the Board: *What is the justification for the doubling of the time required in a residency program? Is there evidence that the one-year program is not adequate or that additional training would reduce the occurrences of medical incompetence, or that there is a correlation to podiatrists who end up being the subject of disciplinary action for incompetent practice or malpractice? To what extent now do podiatrists obtain more than the one-year requirement of training? What impact would this increase have on current and future podiatric residents and to the profession?*

Background: Other professions have also recommended increases in education requirements and the Committee has typically been concerned with such proposals. Increasing the postgraduate training requirement might act as a "barrier to entry" into the profession for new license applicants, possibly delaying their ability to begin their practice, and delaying them from beginning their earning a livelihood from which to pay off the high costs of their education. In past years, the Medical Board of California has also tried to increase its postgraduate training and has not been successful in doing so. The Board maintains that podiatric medicine has become increasingly complex and that one-year of postgraduate training is considered by educators as insufficient prior to entering the practice.

BPM Answer

As podiatric medicine has grown more sophisticated, educators now consider one year insufficient prior to entering practice. The American Podiatric Medical Association (APMA) has advocated two years since 1995. It is designing its residencies accordingly. State licensing boards must account for how educators are defining their programs.

Residents could continue practicing in the training setting, with a limited license. Californians would be provided better-trained doctors. The profession would be enhanced. Licensing exam pass rates would likely increase.

In the 2000-01 Academic Year, there were a total of 122 residents in postgraduate training in California: 76 in year one, 40 in year two, and 6 in year three. Most first-year residents go on to a second year if they are accepted into a second-year program.

ISSUE #2: Existing law limits the terms that can be used in advertising to "podiatrist" and "foot specialist." The Board is proposing to revise the advertising provisions to authorize the use of "doctor of podiatric medicine" and "podiatric surgeon and physician."

Question #2 for the Board: *Why is this necessary? The Board should explain its reasoning and justification for use of these new terms relating to the practice of podiatric medicine. How much of the Board's enforcement activities involves enforcing existing law in this area?*

Background: Business & Professions Code Section 2474 prohibits any person without a valid license from using the terms "podiatrist" and "foot specialist". Currently, the use of "doctor of podiatric medicine" and "podiatric surgeon and physician" is not authorized. The Board points to the fact that its licensees are "doctors of podiatric medicine" – that is the title of both the degree and the license. Further, "podiatric physician and surgeon" is the profession's common terminology nationally. There is an indication that the Board spends some of its enforcement activity enforcing this section of the law. Is it a misuse of the Board's time to go after a DPM (doctor of podiatric medicine) who refers to himself or herself by a title that reflects what they are?

BPM Answer

B&P Code Section 2474 should be amended to include "Doctor of Podiatric Medicine" because that is the title of both the degree and the license.

"Podiatric physician and surgeon" is the profession's common terminology nationally. It is permitted under the laws of 36 states, according to the American Podiatric Medical Association (APMA). *The California Podiatric Physician*, the California Podiatric Medical Association's newsletter, reflects this.

Allowing DPMs to advertise as "podiatric physicians" and "podiatric surgeons" would ***not*** change their scope of practice. It would ***not*** include them in the statutory definition of "physician and surgeon." It would ***not*** permit them to advertise as "Dr." without indicating that they are a DPM.

Many of BPM's cease & desist orders and citations & fines address advertising violations. Most common are violations of B&P Sections 2054 and 2278, which prohibit DPMs from using "Dr." without indicating the type of license, i.e., "DPM." BPM is ***not*** proposing any change to these laws.

Due to BPM enforcement and education efforts, it is unusual today to see a California DPM advertising as a "podiatric physician and surgeon." So long as the law prohibits that, we do too. But we think the law should be changed. Disciplining a DPM surgeon from advertising as a "podiatric surgeon," for example, would beg for reason. It would be a misuse of State resources.

ISSUE #3: The Board of Podiatric Medicine has expressed the desire to standardize licensure requirements across state lines. Currently, BPM does not have reciprocity with other states.

Question #3 for the Board: *How would adoption of the Model Law facilitate reciprocity?*

Background: The Board believes that the standardization of licensing requirements would enhance license reciprocity across state lines – which does not currently exist as all candidates are required to meet all of the California requirements for new licensure including residency training and passage of the state oral exam.

BPM Answer

Currently, California licensees do not face difficult hurdles obtaining licenses in most other states. However, out-of-state DPMs who have been in practice for some years may have difficulty passing California's oral clinical licensing exam.

Switching from the state oral exam to Part III of the National Boards would assist them. As most other states require Part III, many out-of-state applicants would have passed it already within the past 10 years. If they have not, it would still be easier for them to take the Part III exam.

ISSUE #4: Through a review of the Board's licensing activities, it was found that BPM license applications are not abandoned within the regulated one-year period and that applicants are allowed to reactivate applications that have been pending over one year.

Question #4 for the Board: *What steps has the Board taken to address this problem?*

Background: California Code of Regulations 1399.660(c) states that an application shall be denied when an applicant does not complete the application in one year or if the applicant fails to appear for two consecutive oral and clinical examinations. In the event the applicant should subsequently decide to reactivate the application, or take the examination, a new supplemental application shall be filed and the full application fee paid to the Board. In a Department of Consumer Affairs audit, it was found that several applications had been pending from as early as 1992. Some of the applications remain open even though the Board received written notification from the applicant stating they no longer wish to apply for a California license. Also, applicants are allowed to reactivate old applications that have been pending over one year.

BPM Answer

Earlier this year, a report of the Department's Internal Audit Office, *BPM Licensing and Enforcement Review*, found that the Board was not complying with an obsolete section of our BPM regulations, §1399.660 (c).

The report recommended that BPM change its procedures or modify the regulation. BPM voted November 2 to initiate action to rescind the regulation. We use a single, one-stop-shopping application for the limited license for residency, the oral exam, and the regular license. The one-year regulation predates the requirement of post-graduate training and is no longer appropriate.

The licensing coordinator reports there are currently 22 "pending completion" applications, more than one year old, in which the applicant has not completed all prerequisites for obtaining a limited license or (for those who did residency out of state) taking the exam. These are kept for two years in the office and then for five years at the records retention archives. We sometimes fall behind schedule sending files to records retention, due to the press of other business, but that is the office policy.

Files of persons who were either issued a limited license number or took the exam, but who do not go on to apply for regular DPM licensure, are sent to archives for up to 15 years.

SCOPE OF PRACTICE ISSUES

ISSUE #5: Adoption of the Model Law would rewrite the definition of podiatry, largely expanding the scope of practice for podiatrists.

Question #5 for the Board: *What is the definition of "lower extremity"? Would these changes authorize the act of performing amputations and administration of anesthetics? Why such a broad expansion? The Board should discuss and justify.*

Background: The current definition of podiatric medicine is "the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot." (Business and Professions Code Section 2472(b))

The proposed language would define podiatric medicine as "the practice of medicine on the lower extremity, and includes the diagnosis and treatment of conditions affecting the functions of the foot, and local manifestation of systemic conditions as they appear of the lower extremity, and superficial conditions of the leg, by all appropriate systems and means, including the prescribing and administering of drugs and medicines." Additionally, the proposed changes include deletion of the prohibition of podiatrists performing amputations and administering an anesthetic other than local.

BPM Answer

The Model Law provides a better description of what DPMs are trained to do while eliminating some practical problems commonly confronting them because of how they are licensed.

"Lower extremity" is not defined by the Federation's Model Law, or in California law.

The *PDR Medical Dictionary* defines "extremity" as "One of the ends of an elongated or pointed structure. Incorrectly used to mean limb." It lists "lower limb" as a synonym for "lower extremity." It defines "limb" as "an extremity; a member; an arm or leg."

Dorland's Illustrated Medical Dictionary defines "extremity" as the "distal or terminal portion," "an arm or leg," "sometimes applied specifically to a hand or foot."

Regulation of DPMs presents unique problems, because their scope is limited by the license itself. MDs are licensed to perform many procedures in which they may not be competent, for which they are often disciplined. DPMs on the other hand are restricted by their license from performing many procedures in which they are thoroughly trained.

The 1996 UCSF Center for the Health Profession report, *Podiatry's Role in Primary Care,* commented: "Clearly, their broad medical background can and does assist them in providing care to the foot and leg, as well as identifying other biomedical and behavioral problems their patients may have."

Few physicians would advocate specialty licensing. The Model Law attempts to make it work better for DPMs.
It is difficult, for example, for DPMs to explain to patients and medical staffs why they can remove spider veins on the foot, but not finish the job on the portion an inch above the ankle.

Is a fracture of the ankle joint involving damage to the tibia or fibula, inserted into it, an ankle fracture or a leg fracture? Since the early 1980s, the Board has said "yes."

Those are typical of scope of practice questions confronting DPMs every day.

In many health facilities, DPMs are recognized experts in diabetic foot care. DPMs specialize in saving feet and legs, and in the removal of necrotic tissue, i.e., amputations, when necessary. "Amputation" has a strong emotional impact, but is not among the most complex procedures surgeons perform. It is one that many medical staffs delegate to the podiatric surgeon.

BPM's fact sheet *Information on Amputations* [http://www.dca.ca.gov/bpm/pubs/fsamputa.htm], states:

> Section 2472 of the Medical Practice Act defines the scope of practice for a licensed Doctor of Podiatric Medicine (DPM) and states, "No podiatrist shall do any amputation."
>
> Since at least 1983, the Board of Podiatric Medicine (BPM) has interpreted §2472's use of the term "amputation" to mean amputation of the foot in toto. In the opinion of the board, surgical debridement with plastic repairs and/or reconstruction of diseased, traumatized and/or devitalized, nonviable or necrotic tissue has been and continues to be the standard of treatment for these disease processes. . . .
>
> Hospitals are advised to privilege DPMs using the same policies and procedures used for other doctors. Within statutory scope of practice, privileges should be based upon documented training and competence. For more information, please request copies of BPM's *Information for Health Facilities*.

BPM prohibits licensees from performing amputations of the entire foot. This does occur, however. BPM cited and fined one doctor for this violation following substantiation of a complaint.

This law dates to 1921. It is obsolete. Its literal interpretation, if used to prohibit DPMs from amputating necrotic portions of the foot, would disrupt diabetic foot care in California.

Concerning anesthesia, B&P Section 2472 (c) states:

> (c) No podiatrist shall do any amputation or administer an anesthetic other than local. If an anesthetic other than local is required for any procedure, the anesthetic shall be administered by another health care practitioner licensed under this division, who is authorized to administer the required anesthetic within the scope of his or her practice.

It seems unnecessary to specify in law that of all the non-anesthesiology specialists, DPMs are the only ones who must have an anesthesiologist or anesthetist administer the anesthesia.

ISSUE #6: The national Model Law would allow a podiatrist to assist a licensed physician or surgeon in non-podiatric procedures.

Question #6 for the Board: *Is this change aimed at allowing DPMs to do what they are trained to do in podiatric medical school?*

Background: Section 2475 of the Business & Professions Code requires graduates of an approved college or school of podiatric medicine to obtain a "limited" license in order to participate in a postgraduate residency program. Prior to issuance of a limited license, the applicant for a limited license must have passed Parts I and II of the written "national boards" administered by the National Board of Podiatric Medical Examiners. The limited license to participate in the residency program may be renewed annually for up to four years. During that time, a resident is able to practice under the supervision of a licensed physician or surgeon in non-podiatric procedures. However, once licensed, a podiatrist is unable to continue that practice. Under current law, they can only do so acting as unlicensed surgical technicians, not as licensed surgeons.

BPM Answer

Patients and other surgeons frequently want DPMs to assist in leg or knee surgeries due to their expertise and surgical skill, or because of a doctor-patient relationship.

It makes little sense to use a non-licensed technician rather than a DPM to assist in surgery. The DPM graduated from a four-year specialized medical school, completed at least one year of postgraduate training, has extensive surgical experience, and may be better trained in some aspects, e.g., suturing, than the MD surgeon.

The Model Law is not attempting to align DPM practice with the training a podiatric resident receives, which includes most if not all hospital rotations. Comprehensive training is required for any medical specialist. It would be necessary for DPMs regardless of whether they ever assist an MD in a non-podiatric procedure.

The Model Law is designed to utilize their full training, including that received in podiatric medical school, in both:

- their own independent practice of podiatric medicine, and
- MD-supervised assistance in non-podiatric procedures

It would facilitate cross-specialty collaboration, sharing of expertise, and enhanced patient care.

EXAMINATION ISSUE

ISSUE #7: At the Board's last meeting, the Examination Committee recommended a transition from the state oral clinical licensing examination to Part III of the National Board of Podiatric Medical Examiners (NBPME) examination.

Question #7 for the Board: *Will the Board need a statutory change to eliminate the oral exam and require the NBPME Part III written exam?*

Background: The Board has indicated that beginning in 2002, Part III of the NBPME exam will be given in place of the state oral exam. Passage of Part III of the NBPME exam is required under the model law.

BPM Answer

No, the Board does not need a statutory change. It voted November 2 to make this change through rulemaking. However, the Model Law would write it into statute, strengthening the authority for this reform.

BUDGETARY ISSUES

ISSUE #8: Due to recent costly litigation expenses, the Board's budget for Attorney General costs has been nearly exhausted during the first four months of the current fiscal year. Of the $264,577 allotted, only $37,086 remains for the coming eight months.

Question #8 for the Board: *Please explain the reason for these litigation expenses. Why have Attorney General costs increased while the number of cases referred to the Attorney General decreased over the last four years? What is the Board's plan for addressing this deficiency? Will the Board have to stop prosecution of current and future cases?*

Background: BPM has recently been inundated with lawsuits by a particularly litigious licensee (who has recently had his license revoked). This has required the Board to spend its limited resources on unanticipated attorneys' fees to defend itself. The barrage of lawsuits has had such an adverse effect on the Board's fund condition. This is of particular concern to the Committee because of the possibility that the prosecution of other cases will suffer due to the BPM's current budget constraints.

BPM Answer

The Board's budget for AG billings is near exhaustion due to 24 lawsuits from one attorney representing a revoked DPM. The line item was ample for BPM's normal disciplinary caseload.

The Board placed Garey Lee Weber on probation in 1999. After it became clear that BPM would not allow Weber to violate this probation, his attorney filed 24 lawsuits challenging the Board, state laws, and the standard of care. All but 7 of these lawsuits have already been dismissed, but at a great cost in AG billings.

Newspaper headlines like: "Accused podiatrist attempts tough feat: Stomping out board," tell the story. Weber representatives suggested the lawsuits would "go away" if the Board backed away from revoking him. According to CPMA, Weber representatives had stated "that their goal is to bankrupt the BPM." The Attorney General's Office termed it "an obvious effort to retaliate against the Board by diverting resources from its public protection mission to the defense of these retaliatory lawsuits."

The Board has prepared a Deficiency Budget Change Proposal (BCP) to augment the current year budget. This was made possible by support from the profession, Administration, and the Legislature for SB 724 (Statutes of 2001, Chapter 728). Authored by Senate B&P, this bill extended the temporary renewal fee increase, raising it from $800 to $900 biennially, for another two calendar years.

If the BCP is approved, BPM will have continued funding to support the AG's representation for both administrative (disciplinary) and civil (lawsuit) matters. We anticipate dismissal of the remaining lawsuits before long.

ISSUE #9: SB 724 (Senate Business and Professions Committee), Chapter 724, Statutes of 2001, extended the Board's temporary fee increase for license renewal for two additional years. However, factors such as a drop in the number of licensees as well as an increase in expenses continue to contribute to a decline in the Board's reserve level.

Question #9 for the Board: *Does the Board anticipate that the temporary increase will remedy their declining fund condition or should the $100 fee increase become permanent?*

Background: The number of licensees under BPM's jurisdiction was 2,134 in FY 92/93. Since then, that number has declined, dipping to 1,755 for FY 00/01. Because BPM's operations are supported solely through fees it assesses, with the greatest amount coming from biennial license renewals, this decrease has been a source of considerable concern for the Board. Because of its dwindling licensee base, BPM has explored numerous ways to ensure the continuation of its regulatory programs. Effective January 1, 2000, its licensing fees were temporarily raised from $800 to $900 biennially — and upon enactment of SB 724 the temporary fee increase will be extended through December 31, 2003. At this point in time, it is uncertain whether the additional two years of the fee increase will provide enough revenue to stabilize BPM's fund condition.

BPM Answer

Managed care has reduced the number of our licensees, and our revenue. Our *Strategic Plan* was an attempt to prevent the fee increase from having to be extended. It sought to lower expenses by emphasizing use of the continuing competence and citation & fine programs. The goal of continuing competence is to prevent patient harm, rather than simply respond to it through expensive discipline. Citations and fines are less costly than formal discipline.

Unfortunately, the Weber lawsuits necessitated extension of the fee increase. There is still illegal activity that BPM will prosecute as complaints are received and violations are substantiated. As the financial stakes for those involved may be significant, more challenges may lie ahead. Absent future lawsuits, it may not be necessary to make the fee increase permanent.

CONTINUING COMPETENCY ISSUES

ISSUE #10: At the last review of the BPM, a continuing competency program was implemented. The Board is proposing to "refine" the continuing competency requirements.

Question #10 for the Board: *How is the continuing competency program working? What is included in the Board's proposal to refine the program? Will these changes negate the need for issuance of waivers? Would the Board recommend similar continuing competency changes to other health-related boards?*

Background: Through SB 1981, Chapter 736, Statutes of 1998, the Board initiated the first continuing competence program for any doctor licensing board in this country. Under Business and Professions Section 2496, each licensee must self-certify under penalty of perjury at each biennial license renewal that she or he meets at least one of seven peer-review-based pathways for re-licensure. Licensees who have been licensed for more than 10 years, have no peer-reviewed health facility privileges, and are not board certified, must either take the BPM's licensing exam or complete a special training course sponsored by an approved school under Business and Professions Code Section 2496(g). BPM has approved such a program sponsored by the California College of Podiatric Medicine in conjunction with the California Podiatric Medical Association. However, according to the Board, administrative transitions in both of those institutions have hampered the program's development.

The Board reports that its objective has been to phase the continuing competence program in as a pilot. Implementation of the Model Law would refine the continuing competence requirements based on the Board's experience to date and would provide additional pathways and ease compliance for the few who lack health facility privileges and are not certified by an approved specialty board.

BPM Answer

The continuing competence program is working well. BPM recommends similar initiatives to other health boards.

The Pew Health Professions Commission's *Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century* (1995), stated:

> The evidence that continuing education cannot guarantee continuing competence is sobering. State legislatures will be challenged, therefore, to require each professional board to develop continuing competence requirements that do not rely on continuing education. . . . State boards may not have to require re-testing for all practitioners. Private board certification and re-certification or institutional competence assessments may serve as appropriate proxies if states determine they guarantee continuing competence.

Aside from a lawsuit--one of the 24--from Garey Weber's attorney, there has been no opposition to this program. The CPMA supported our proposal in the Sunset Review four years ago.

As stated in our current *Sunset Review Report*:

> The first two-year renewal cycle of the continuing competency requirement has concluded. In all, less than 2% of the active licensing population has been issued a waiver for this requirement. Since January 1, 1999, when the law took effect, staff has issued 15 temporary waivers and 13 permanent waivers for continuing competence. It appears that the number of temporary waivers will level off and there will be a slight increase in permanent waivers as the number of retired licensees increases.

The Model Law would make the following changes in B&P Section 2496:

> 2496. In order to insure the continuing competence of persons licensed to practice podiatric medicine, the board shall adopt and administer regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) requiring continuing education of those licensees. The board shall require those licensees to demonstrate satisfaction of the continuing education requirements and one of the following requirements at each license renewal:
>
> (a) Passage of an examination administered or approved by the board within the past 10 years.
> (b) Passage of an examination administered by an approved specialty certifying board within the past 10 years.
> (c) Current diplomate, board-eligible, or board-qualified status granted by an approved specialty certifying board within the past 10 years.
> (d) Recertification of current status by an approved specialty certifying board within the past 10 years.
> (e) Successful completion of an approved residency or fellowship program within the past 10 years.
> (f) Granting or renewal of current staff privileges within the past five years by a health care facility, clinic, center, or organization that is licensed, certified, accredited, conducted, maintained, operated, funded or otherwise approved by an agency of the federal, ~~or~~ state or local government or an organization approved by the Medical Board of California.
> (g) Successful completion ~~of an approved course of study of at least four weeks' duration at an approved school~~ within the past five years of an extended course of study approved by the board.
> (h) passage of the part of the National Board of Podiatric Medical Examiners of the United States examination testing for clinical competence within the past ten years.

These changes would ease compliance for older licensees who are neither hospital privileged nor board certified. Of the seven original pathways, (g) needs amendment because administrative changes at the California College of Podiatric Medicine and California Podiatric Medical Association hampered anticipated development of a program. The proposed eighth pathway, (h), would be more realistic for older licensees than the BPM's current oral clinical exam.

These changes will provide BPM an alternative to waiving the requirement or terminating the licenses of older practitioners. Providing for a BPM-approved course of study and the National Boards Part III as new alternatives would protect the public without forcing these older licensees out of practice for lack of a reasonable pathway. As licensees become accustomed to these requirements, e.g., maintaining certification or privileging, we anticipate tightening the pathways.

ISSUE #11: BPM has indicated that their licensing coordinator "is preparing" to conduct random audits.

Question #11 for the Board: *Are CME audits occurring now? If not, when does the Board anticipate that these audits will be conducted? How long has it been since the discontinuation of audits by the Medical Board?*

Background: Due to high costs associated with contracting with the Medical Board staff to conduct random audits of continuing medical education (CME), the Board decided to discontinue the audits for CME. In turn, the Board will have to rely on its own licensing coordinator to perform the CME audits. It is unclear if audits are being conducted currently.

BPM Answer

CME audits are conducted of probationers and licensees investigated because of complaints. The licensing coordinator has not yet re-initiated random audits.

BPM now places more importance on the continuing competence requirement, which the licensing coordinator administers. Like others on the five-person staff, she has been impacted by the Weber lawsuits. The lawsuits challenging the limited license for residents and the continuing competence program have been especially demanding of her time. Also, the oral exam is labor intensive.

Random CME audits, in this context, have been low priority. The last such audit was conducted by MBC and BPM staff in June 1999. BPM staff plans to resume random audits in 2002 following the successful transition to the National Boards Part III.

ENFORCEMENT ISSUES

ISSUE #12: It is unclear to what extent, if any, BPM Board members are engaged in reviewing incoming complaints.

Question #12 for the Board: *What is the process by which the Board reviews incoming complaints and determines whether the complaint should be sent out for investigation? Are Board members involved in that process?*

Background: BPM typically uses outside podiatrists on contract to review incoming complaints. However, because of costs associated with contracting out, there are some indications that BPM has used Board members to review incoming complaints. This is not a practice that the Joint Committee supports because of the inherent problems that can result. This would permit board members to recommend, at a very early stage in the process, that a complaint be moved out for investigation (i.e., a complaint against a competitor) or dismissed (i.e., a complaint against a friend).

BPM Answer

BPM Board Members do not review complaints. BPM follows the same complaint procedures as the Medical Board, utilizing the Medical Board's Central Complaint Unit.

In 1998-99, prior to enactment of the fee increase for calendar years 2000 and 2001, BPM did experiment with having its four licensee Board Members review one or two complaints each as *pro bono* medical consultants. This was one of several temporary emergency measures prior to enactment of the fee increase in 1999. Fewer than eight complaints were so reviewed. It was emphasized and understood that the Board Member would have to recuse herself or himself if the matter ever came before the Board to decide as a jury. That never occurred, and the experiment was terminated in 1999. BPM does not permit its DPM consultants to review complaints against competitors or friends, and maintained this same policy during the experiment utilizing Board Members.

ISSUE #13: It has been indicated that BPM may be issuing citations and fines for quality of care violations such as repeated negligent acts and gross negligence. There is concern that such cases should be pursued as disciplinary matters rather than just a citation and fine.

Question #13 for the Board: *To what extent is the Board issuing citations and fines for quality of care violations? When did BPM add Business and Professions Code 2234 to the regulation that lists the kinds of violations for which a cite/fine is appropriate?*

Background: Concerns have been raised that in some instances citations have been issued for quality of care complaints, such as those involving gross negligence or repeated acts of negligence by the podiatrist. Normally, such cases should trigger a disciplinary proceeding aimed a revocation and/or suspension of the podiatrists license. It does not appear that Medical Board would use its cite and fine authority for such these types of violations. Additionally, BPM also amended its cite and fine regulation to require its executive officer to have approval of an expert review (i.e., a podiatrist). This is not a requirement of the Medical Board.

BPM Answer

After the Medical Board staff proposed adding Section 2234 to its citation and fine authority, BPM staff did likewise. The Medical Board did not approve this, BPM did. BPM's proposed regulatory change was approved by the Medical Board, the Department of Consumer Affairs, and the Office of Administrative Law. It took effect in February 2000.

The inclusion of Section 2234 in cite and fine authority gives BPM the flexibility and option of issuing a citation for repeated negligent acts (e.g., two acts with same patient, or one act each with two patients) that its medical reviewers consider *simple* as opposed to *gross* negligence. This could provide an option in a case where the Attorney General declined to prepare an Accusation seeking discipline. However, BPM has yet to issue any citation under Section 2234.

During the Board's consideration of this proposed regulation, an attorney representing Garey Lee Weber advocated that Board Members should review any case prior to a citation being issued. The Board rejected this proposal. It did amend Section 1399.696 (a) of its regulations, effective August 2001, to reflect the longtime standing operating procedure of both the BPM and the Medical Board:

> In all cases concerning medical quality of care, or requiring medical judgement, the executive officer shall base his decision on the findings of a board-approved medical consultant or expert.

This change was also approved by the Medical Board, the Department, and the Office of Administrative Law.

ISSUE #14: There are excessive delays in processing complaints, investigations, and prosecuting cases.

Question #14 for the Board: *Is the Board currently working with the Medical Board to identify reasons for delays in investigations and develop possible solutions?*

Background: The average processing time is: 86 days to process a complaint; 331 days to investigate a complaint; 77 days from completed investigation to formal charges filed; 462 days from formal charges filed to conclusion of disciplinary case; and 1,058 days total (approximately 3 years) from the date a complaint was received to the date of final disposition of a disciplinary case.

Although the total number of days has decreased by almost one year (the last review showed an average of 1396 days), the delays are still excessive.

***It must be noted that BPM contracts with the Medical Board's Central Complaint Unit and Enforcement Program staff to conduct their complaint handling.**

BPM Answer

The statistics in our *Sunset Review Report* under Case Aging Data show that processing times have decreased significantly since the review four years ago:

AVERAGE DAYS TO PROCESS COMPLAINTS, INVESTIGATE AND PROSECUTE CASES				
	FY 1997/98	**FY 1998/99**	**FY 1999/00**	**FY 2000/01**
Complaint Processing	**132**	**67**	**86**	**69**
Investigations	**355**	**418**	**300**	**252**
Pre-Accusation*	**102**	**74**	**86**	**45**
Post-Accusation**	**707**	**323**	**334**	**483**
TOTAL AVERAGE DAYS* **	**1361†**	**1232†**	**688†**	**952†**

*****From completed investigation to formal charges being filed.
******From formal charges filed to conclusion of disciplinary case.
*******From date complaint received to date of final disposition of disciplinary case.
† This is not the sum of the above numbers because the disciplinary cases finalized in each fiscal year may or may not be the same as the complaints or accusations filed in that same year.

However, the goals of B&P Section 2319 are still not being met:

> 2319. (a) The board shall set as a goal the improvement of its disciplinary system by January 1, 1992, so that an average of no more than **six months** will elapse from the receipt of complaint to the completion of an investigation.
> (b) Notwithstanding subdivision (a), the goal for cases which, in the opinion of the board, involve complex medical or fraud issues or complex business or financial arrangements should be no more than **one year** to investigate.

These goals, enacted in 1990 with BPM support, apply to the entire Medical Board caseload, of which DPM cases are only a small part. The six and twelve month goals apply to the entire MBC caseload on "average." Within this caseload, podiatric cases are not always at the top of the Medical Board's priority system.

Averages can be misleading. One case pending at the AG for more than four years is an Accusation against William Moalem. Following the initial quality-of-care Accusation, Moalem was arrested while employed by Garey Lee Weber. In 1999, he was convicted on the criminal first-degree murder charges. The Accusation to revoke his license was amended based on the felony conviction, but cannot be processed until he exhausts his appeals of the murder conviction. He is imprisoned, and suspended from practice. BPM staff was integral to the felony investigation and conviction.

BPM hired a full-time enforcement coordinator in the early 1990s to support MBC and AG staff. She utilizes specialized statistical reports to monitor comparative data on DPM and MD cases, and works with our investigators and attorneys on a daily basis to expedite the case flow.

It seems that the timelines for DPM cases are similar to those for MDs. The time frames reflect limited staff in Central Complaints and the field. Revenues from MD and DPM renewal fees are the limiting factor. BPM's fees have been higher than the Medical Board's since the 1980s. It is problematic to continue raising them beyond the amounts for physicians.

ISSUE #15: Since the last review of the Board, there has been a decrease in the number of investigations opened.

Question #15 for the Board: *To what does the Board attribute this reduction?*

Background: The average of 85 investigations per year has decreased to an average of 53.

BPM Answer

Because of resource constraints, BPM's Enforcement Coordinator has urged MBC Central Complaints staff and our own DPM consultants to screen cases more carefully prior to sending them to the field for formal investigation. In addition, the cumulative effect of 10 years of no-nonsense enforcement has had a deterrent effect on violations.

NUMBER AND PERCENTAGE OF COMPLAINTS DISMISSED, REFERRED FOR INVESTIGATION, TO ACCUSATION AND FOR DISCIPLINARY ACTION				
	FY 1997/98	**FY 1998/99**	**FY 1999/00**	**FY 2000/01**
COMPLAINTS RECEIVED	**210**	**271**	**195**	**229**
Complaints Closed	152 – 72%	222 – 82%	168 – 86%	184 – 80%
Referred for Investigation	**59 - 28%**	**56 – 21%**	**53 – 27%**	**42 – 18%**
Accusation Filed	12– 6%	13 – 5%	5 – 3%	10 – 4%
Disciplinary Action	7 - 3%	20 – 7%	9 – 5%	10 – 4%

CONSUMER SATISFACTION ISSUES

ISSUE #16: According to the Complainant Satisfaction Survey conducted by the Board, consumer satisfaction is very low.

Question #16 for the Board: *Does the Board have a plan for addressing these concerns?*

Background: Only 25% of consumers were satisfied with the overall service provided by the Board. Other areas of concern include dissatisfaction with the: a) informative measures taken during the handling of a complaint, b) time to process complaint, and c) final outcome.

BPM Answer

These consumer ratings concern services provided by Medical Board personnel. As indicated, MBC is probably under-funded and under-staffed. Its civil servants deserve recognition and more support.